Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
COVENANT MEDICAL CENTER
PO BOX 1866
FORT WORTH TX 76101

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-07-3918-01

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
#19

MFDR Date Received
February 22, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Request for Reconsideration letter dated September 26, 2006: "Please see attached bill and process for reconsideration again. The pharmacy charges were not paid correct. The charges needs to pay cost + 10%. The Charge for the antivenin was $2133.67 per dose and there were 34 doses. The reimbursement should have been $35175.60, you only paid $4694.07."

Requestor's Supplemental Position Summary as stated on the 2nd Request for Reconsideration letter dated December 5, 2006: "Please see attached bill and process for reconsideration again…There was a payment of $4694.07 received for 2...."

Amount in Dispute: $35175.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary (from AIG Audit Department) Dated October 19, 2006: "We have received a request for reconsideration. No further allowance is recommended at this time. The bill was paid according to state fee schedule guidelines. Review of the invoice submitted shows payment has been made correctly for 2 cartons of antivenom used for this patient."

Respondent's Position Summary Dated March 23, 2007: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable."

Responses submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
May 3, 4, and 5, 2006	Antivenin	$35,175.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 1 (W1) – workers compensation state fee schedule adjustment
- 2 (42) charges exceed our fee schedule or maximum allowable amount
- 3(24) – payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan

Issues

1. Did the requestor support its billing of 17 doses of antivenin?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $6008.50 for Antivenin snake vial. The requestor submitted one invoice dated May 5, 2005 as documentation to support what the cost to the hospital was for an Antivenin snake vial. Review of the requestor's itemized statement finds that the following pharmaceutical was billed and is therefore eligible for reimbursement at cost plus 10%:

Ref. Num.	Itemized Statement Description	Invoice #4807189 Description	Units/cost per unit	Total cost	Cost + 10%
0027651	Antivenin snake vial – 12	Antivenin crotalidae polyvlnt sz: 2x1ea	2 @ $2133.67 each	$4267.34	$4694.07
0027651	Antivenin snake vial – 13	No invoice provided	Not Supported	NA	NA
0027651	Antivenin snake vial – 9	No invoice provided	Not Supported	NA	NA
			TOTAL ALLOWABLE	$4694.07	

2. Although the requestor is disputing that additional reimbursement for a total of 32 doses of antivenin is due, the documentation found does not support the cost for those additional 32 doses. The division concludes that the total allowable for the two doses of antivenin supported is $4,694.07. The respondent issued payment in the amount of $4,694.07. No additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. No additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		October 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		October 2012
Signature	Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.